EXHIBIT B-2

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: VENTRESS-0845

Patient Name: (Last, First) Strickland Willie

Date: (mm/dd/yy) 2.25.05

Site Phone # 334-7758178

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax # 334-775-8178

Inmate # 226537

PHS Custody Date: (mm/dd/yy) ___/___/___

Will there be a charge? ☐ Yes ☐ No

Sex ☑ Male ☐ Female

SS Number ___-___-____

Potential Release Date: (mm/dd/yy) ___/___/___

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr. Rayapati

Facility Medical Director Signaure and Date:

Samuel Rayapati MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Dr Wheeler

History of Illness/injury/symptoms with Date of Onset:

Small RT # - with No Significant Sac. easily Reducible

Results of a complaint directed physical examination:

P/E - Examination reveals no significant changes from the past

Previous treatment and response (including medications):

Now prescribed - TRUSS

FOR PROFESSIONAL USE ONLY
CONFIDENTIAL RECORD
NOT TO BE PHOTOCOPIED

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

Fax 2-28-05